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A Follow-Up Study Juvenile Commitments to the Milwaukee County Hospital for Mental Diseases from 1938 to 1947 Inclusive

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A FOLLOW-UP STUDY OF JUVENILE COMMITMENTS TO THE
MILWAUKEE COUNTY HOSPITAL FOR MENTAL DISEASES
FROM 1938 TO 1947 INCLUSIVE

by

Margaret Fitzgerald Rice

A Thesis Submitted to the Faculty of the School of Social Work
of Loyola University in Partial Fulfillment of
the Requirements for the Degree of
Master of Social Work

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1954

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INTRODUCTION

Purpose

The purpose of this study is to analyze the type of adjustment which a select group of juvenile commitments to the Milwaukee County Hospital for Mental Diseases has been able to make over a given period of time.

Limitations

The study is limited to seventy-one children under the age of eighteen who were committed during the ten year period from 1938 to 1947 inclusive. The cases were selected below age 18 because only in this age group do the juvenile authorities have sole jurisdiction. This particular period ending with 1947 was chosen because it was felt that a substantial period of time should have elapsed to render the follow-up of these cases meaningful.

Sources

The sources of information included hospital records and personnel, city directories, home and collateral visits, telephone calls and letter to families, other institutions, agencies and the police.

Method

To co-ordinate the data obtained a schedule was drawn up (see Appendix I). Direct contact was possible in practically every case, either through this or other hospitals or institutions in the cases

of those still institutionalized, or through home visits, telephone calls and other agency contacts in the cases of those no longer in institutions.

Setting

The setting for this study was the Milwaukee County Hospital for Mental Diseases, Milwaukee, Wisconsin. This hospital, commonly known as HMD (this abbreviation will be used throughout the study) was established by Act of the Legislature in 1878 and named the Milwaukee County Insane Asylum. The new name was assigned to it in 1917. Juveniles are committed here through the Children's Court of Milwaukee County. The hospital has 1,018 beds and from time to time old chronic cases are transferred to the Asylum for the chronic to make room for the new acute population. The hospital constantly has a population of over 1200 and has had a peak load of 1283. An extensive educational program for doctors, student nurses, occupational therapists and dietetics students is carried on here as well as the training of psychiatric attendants. There is an affiliation with the Marquette University medical school, and senior medical students are assigned to the hospital for their psychiatric training. Recently the psychology department has been expanded and training of psychologists has been added to the educational facilities. The hospital is desirous of inaugurating a training department for social workers but, to date, has been unable to secure a trained, qualified person to supervise this undertaking.

The tested methods of modern treatment for the mentally ill such as insulin shock, electro-shock (with or without anectin), metrazol

shock for certain cases, anti-luetic therapy, industrial, recreational, occupational and music therapy are engaged in extensively. Because of limited medical personnel, it is possible to carry on only a small degree of individual psychotherapy. However, group therapy is now being carried on for groups consisting of from seven to twelve patients with a psychiatrist and a psychologist direct this activity. The results, in general, have been very satisfactory and a number of out-patients return to the hospital for these group sessions. Psychodrama, under the direction of a psychologist, is a recently added treatment. Unfortunately there are no separate quarters for the small juvenile population and they are exposed constantly to the behavior of the adult psychotics.¹ Plans have been drawn up for a new hospital which will include special quarters for children but, as yet, this unit is not under construction.

Plan of Presentation

Chapter I will contain identifying data covering all juvenile cases admitted to the hospital during the ten year period. Chapter II will be concerned with the patients presently institutionalized either in mental hospitals or penal institutions while Chapter III will deal with cases no longer in institutions. Chapter IV will consist of a summary and conclusion.

1 Since this research was made a teacher has been added to the staff to conduct an educational program for the children .

CHAPTER I

IDENTIFYING INFORMATION

In this chapter will be included the proportion of juveniles to the entire hospital load, a breakdown by age and sex, diagnoses, prognoses and present status, familial history of mental illness, home situation and general intelligence of those admitted.

Proportion of Juveniles

The following table shows the proportion of children admitted during the study period.

TABLE I

PROPORTION OF JUVENILES TO TOTAL HOSPITAL LOAD

Year	Adults	Juveniles	Total
1938	512	8	520
1939	493	7	500
1940	535	8	543
1941	533	9	542
1942	565	5	570
1943	555	6	561
1944	497	7	504
1945	611	7	619
1946	594	9	603
1947	588	5	593
Total	5483	71	5554

Of the seventy-one juvenile cases, forty-five were admitted for the first time

and twenty-six were returned, having been previously committed and returned because of inability to adjust. Only slightly over one per cent of the admissions are children, a fact which indicates why this particular hospital must be set up primarily for the treatment of the adult psychotic.

The following table will indicate the breakdown of these child patients by age and sex.

TABLE II

SEX AND AGE

Age	Sex		
	Male	Female	Total
9	2	-	2
10	1	-	1
12	4	-	4
13	3	-	3
14	5	6	11
15	8	2	10
16	7	9	16
17	15	9	24
Total	45	26	71

Age

It is to be noted that, in general as the age increases, there are more

admissions among juveniles. At age 17, approximately thirty-four per cent of the total were admitted, at age 16, twenty-two per cent, at age 15, fourteen per cent, at 14, fifteen per cent, and the remaining fifteen per cent were scattered in four groups from ages thirteen to nine inclusive.

This, however, does not necessarily mean that breakdowns occur more frequently in these advancing adolescents. In many cases, there have been histories of asocial, anti-social or peculiar behavior pre-dating the patient's hospitalization by many years. Advancing adolescence may well bring to fruition many basic emotional disturbances but can hardly be considered a determining factor in the ultimate breakdown. Furthermore, there is ignorance on the part of many parents regarding just what constitutes peculiar behavior. It was simple enough for the parents of one young patient who poured kerosene on his dog and set it afire to realize that this sort of activity was not normal. However, it is more difficult for the parents of a docile little child who sits quietly day after day playing with his toys or day-dreaming, causing no disturbance, to understand that they may have a very sick youngster on their hands. In addition, there is the natural reluctance of parents, like other human beings, to admit failure or the need of help. Unless behavior is very bizarre and in conflict with society, there is a tendency to shield, protect or over-protect the child in the home until the situation becomes totally unacceptable. And, in all fairness to parents, it must be admitted that part of their re-

luctance to seek guidance has been the lack of suitable facilities for the treatment of children and the stigma attached to commitment procedures. They commit only as a last resort, either because of their love for their children or their feeling of guilt regarding their own rejection and their failure as parents.

Sex

From the table it is obvious that there are a great many more boys than girls committed to the hospital, approximately sixty-three per cent male to thirty-seven per cent female.

Strangely enough, this is true of mental hospital loads in general but there has been no evidence by which one might conclude that the male is more prone to breakdown than the female. Perhaps part of the answer lies in the essential natures of the male and female and accepted attitudes toward each.

There may be a tendency to protect the girl to a greater extent and, too, her manifestations in general are not quite so likely to be as overt and as greatly in conflict with society as those of the boy.

After the children were admitted to the hospital, they received intensive physical and psychiatric study and, in the normal course of events, were labelled with their respective diagnoses. It is not quite so simple

a matter to render a diagnosis on children as it is on adults, barring of course physical findings. In many cases their behavior has not "jelled" into a permanent category. Some are placed in the primary behavior disorder classification until further manifestations become evident or further study is undertaken.

Table III presents the clinical classifications of the mental disorders for which these children were admitted as well as the correlation between their diagnosis and their present status.

TABLE III

CORRELATION OF DIAGNOSIS
WITH PRESENT STATUS

Diagnosis	Present Status				
	Outside	Mental Hospital	Penal Institution	Deceased	Total
Dementia Praecox	20	13	-	-	33
Convulsive	2	1	-	-	3
Psychopathic Personality	3	1	2	-	6
Primary Behavior Disorder	3	2	3	-	8
Psychoneurosis	2	-	-	-	2
Undiagnosed Psychosis	2	-	-	-	2
Psychosis with Mental Deficiency	2	1	-	-	3
Post-encephalitis	1	1	1	-	3
Manic-Depressive	3	-	-	-	3
Juvenile Paresis	-	2	1	-	3
Organic Changes	-	-	-	2	2
Without Psychosis	3	-	-	-	3
Total	41	21	7	2	71

Diagnosis

From a study of this table, the largest grouping, over 46% fell in the schizophrenia classification, with the other 54% scattered in eleven different categories.

Correlation of Diagnosis with Present Status

From a further examination of the table we find that about 30% of all the juveniles are in mental institutions, 58% reside outside of institutions, 10% are in penal institutions and 2% are deceased. Thirteen of the patients classified as Dementia Praecox are presently in mental hospitals and twenty are living outside.

The one psychopath who is in a mental hospital is clear but requires supervision and would be able to leave the institution if someone would be willing to be responsible for him. The three psychopaths outside seem to be making no more than marginal adjustments and at least one of them has been in recent conflict with the law. The two primary behavior disorders who are still hospitalized also have very low average intelligence, thus complicating their situations. Of the three who are outside, adjustments of two are marginal and of the other poor. Two of them have been in conflict with the law and are on probation. One is potentially dangerous but his family refuses to re-commit him although he has recently been picked-up for mental observation and commitment was recommended.

The two psychoneurotics are adjusting quite well and further hospitalization has not been required. One is engaged in congenital work and the other has a patient understanding mate. Those of the undiagnosed group were discharged and have had tempestuous, aimless careers but have exhibited no outright psychotic behavior. The mental defective, classified

imbecile, has been transferred to the chronic institution and is still hospitalized and very deteriorated. Of the two outside, both are silly and childlike. Both are female and one is married, the other illegitimately pregnant. Of the post-encephalitics, the hospitalized patient is deteriorated and requires constant supervision. The one outside is twenty-three, is attending college spasmodically and is now a sophomore. The other is in the Industrial School and has stolen cars, left the scene of an accident and has been picked up for assault. The three manic-depressives are recovered from their episodes. All three are female and are making good adjustments. Of the paretics, two are still hospitalized, one very deteriorated, the other improved. The other was last known to be in a state industrial school, offence unknown.

The fact that schizophrenics live outside than inside, about 61% to 39%, is rather more encouraging on the face of it than is actually the case. Many of these patients are making no more than marginal adjustments and have been in and out of the hospital many times since their first admission. Of the praecoxes 19 were male and 14 female, approximately 58% of the total being male and about 42% female. On the basis of the admissions which comprised 63% male and 37% female, there is little to indicate that either sex is more prone to schizophrenia than the other.

Also in the case of the manic-depressives, the statistical picture appears more hopeful than the total picture because two of them have had several admissions to the hospital and one has been out only about two years. It is interesting to note that two psychopaths as well as three years primary behavior disorders are represented in penal

institutions. This course of events is in keeping with their diagnoses because these types of personality are frequently in conflict with the law.

Prognosis

In general a prognosis is established at the time a patient is diagnosed although, in many of the earlier cases, no prognosis whatsoever was available from the record. The following table illustrates correlation of prognosis, which was rendered by the medical staff at the time the patient was staffed, with the present status.

TABLE IV
CORRELATION OF PROGNOSIS
WITH PRESENT STATUS

Prognosis	Present Status				Total
	Outside	Mental Hospital	Penal Institution	Deceased	
Good	8	3	-	-	11
Fair	3	2	-	-	5
Guarded	9	7	3	-	19
Poor	10	7	3	1	21
None	11	2	1	1	15
Total	41	21	7	2	71

It is interesting to note that an almost equal number of good, guarded and poor prognoses are able to live outside of institutions. However, in general, the adjustment of those with favorable prognoses has been better than that of the individuals with poor prognoses. The

total adjustment of these individuals will be discussed in detail in Chapter IV.

Familial History of Mental Illness

To what extent was mental illness found in the families of these children? Of the seventy-one cases, thirty-five cases revealed histories of mental illness in the family and thirty-six did not. This statistic revealed no evidence that the children of families wherein evidence of mental illness was found were any more susceptible to mental disintegration than those from families who were afflicted. There is some evidence, however, that certain children of psychotic parents, falling under their guidance and domination, are affected emotionally and do become psychotic but they are in the minority. A further study along these lines might be interesting and useful. It is now a generally accepted fact that mental illness is not inherited with the exception of the small percentage of cases which are organic in origin such as paresis, Huntington's Chorea, etc.

Home Situation

In attempting to arrive at some sort of an evaluation of the home situation, the writer read the records, culling out the impressions of the parents or guardians and their attitudes toward the children. Of all the cases only one seemed to come from a home where an entirely happy life prevailed. Nineteen were only fair and fifty-one could be counted poor. Being a public institution, the majority of the families were of rather poor or modest financial means. However, several were well-to-do or prosperous. Many families indicated histories of delinquencies in parents and siblings, drinking, immorality, marital strife, poor super-

vision, neglect, paucity of social and religious training and a definite lack of an integrated family relationship. There seemed to be no correlation between financial dependence and breakdown. On the other hand, the lack of emotional security within the home was evidenced in the vast majority of the cases.

General Intelligence

Forty-nine were found to be of average intelligence, ranging from 90 to 110. Eighteen were retarded with a spread from 50 to 85 and four were superior with one IQ ranging as high as 135 to 140¹. By and large the greatest group falls in the average IQ level, about 70%. On the basis of this study it would seem that the rank and file of children are just as prone to mental illness as their brighter or duller brothers and sisters.

There seems to be no correlation between intelligence and mental illness. A fond parent's often repeated phrase "He was just too smart" has no basis in fact and is often a panacea for the parent's own feeling of outrage or inadequacy. The boy who ranged to genius IQ has never been able to make more than a marginal adjustment although he is now twenty-seven years of age. His most sustained occupation, lasting a few weeks, was that of stevedore and there is reason to believe that he is now deteriorated. He is extremely paranoid, refused for years to leave the institution and now sits idly in the home.

1 The hospital does not care for the feeble minded; they are transferred to the chronic or to state institutions.

Another patient of superior intelligence is in the Air Corps and is adjusting. Another works at skilled labor but remains seclusive and other is in a correctional institution. None have achieved the success that their IQ's have warranted. Neither can we say that the retarded children are more prone to mental illness. Most of them never become mentally ill and manage to find niches where they can operate at their own level of achievement. Of the eighteen retarded, some organic and others are outside of institutions, making both good and poor adjustments the same as the superior group.

Summary

Concerning the seventy-one juveniles under the age of 18 who were committed to HMD from 1938 to 1947 inclusive, it was found that they formed only slightly over one per cent of the entire number of persons committed, from which we must deduce that this institution must necessarily be set up for the care of the adult psychotic.

As the age of the child advanced, admissions increased, 34% being admitted at seventeen, 22% at sixteen, 14% at fifteen, 14% at fourteen and the remaining 15% scattered in four groups from ages thirteen to nine inclusive. It was felt that other considerations besides crystallization of behavior as the adolescent advanced in age entered into the situation. These factors were the inability of the parents to recognize psychotic behavior, their natural rejection of the thought that they may have failed as parents and their honest distaste for committing their children to an institution which is not primarily set up to care for their needs.

Sixty-three per cent of admissions were male and 37% female, which

does not necessarily indicate that the male child is more prone to break-down than the female. It was felt that the essential natures of the male and the female, causing the male to be more aggressive, overt, and at odds with society as well as the generally accepted attitude of protection of the female may be a factor in greater male admission.

Over 46% fell in the schizophrenia grouping with 54% scattered in eleven other different categories. Fifty-eight percent of the schizophrenics were male and 42% female with no indication that either sex is more prone to dementia praecox. Sixty-one percent of the schizophrenics live outside of institutions and 39% inside, this fact appearing rather more hopeful than is the case because many who are outside are making only marginal adjustments and have had a history of many admissions.

Thirty per cent of all cases are in mental institutions, 58% reside outside, 10% are incarcerated and 2% deceased.

The psychopaths and primary behavior disorders are well represented in penal institutions which is not surprising because this is in accordance with the particular behavior patterns of these types of individuals.

All manic depressives are currently outside of institutions but have had and are subject to further recurrences of their episodes.

An An almost equal number of good, guarded and poor prognoses are able to live outside, with the better prognoses in general making the better adjustments, a matter which is discussed fully in Chapter IV,

In thirty-five of the seventy-one cases, a familial history of mental illness was revealed whereas thirty-six produced no such history, leading us to believe that there is little evidence of mental illness being

handed down from generation to generation.

From an examination of the home situations, fifty-one were deemed poor, nineteen fair and only one good, invoking the thought that poorly integrated family relationships may well have a decided bearing on the disintegration of personality.

Forty-nine of the children were found to be of average intelligence about 70%. Eighteen were retarded and four were superior. There was no evidence to indicate that there is any correlation between intelligence and mental illness.

CHAPTER II

CASES PRESENTLY IN MENTAL HOSPITALS OR MENTAL INSTITUTIONS

This chapter will include the twenty-eight cases which were, at the time of the study, housed in mental hospitals or incarcerated in penal or correctional institutions. The first portion of this chapter will include those patients currently hospitalized as to age, sex, diagnosis, prognosis, and treatment, personality and reason for admission, familial history of mental illness and home situation, intelligence and previous health history, number of admissions and last known conditions. The second portion will deal with the incarcerated, covering the above data, plus the offenses for which they were imprisoned.

Patients in Mental Hospitals

The following table indicates the number of patients by sex who are still in mental institutions and the facilities which are serving them.

TABLE V
PATIENTS IN MENTAL HOSPITALS

Facility	Male	Female	Total
HMD	9	2	11
Asylum (Chronic)	3	4	7
State Institutions	1	2	2
Veterans' Hospitals	1	-	1
Total	13	8	21

The patients remaining at HMD have responded poorly to treatment in general and are bordering on chronic cases. The transfers to the Asylum, institution for chronic cases, were, as the term implies, chronic and had failed to improve over a period of years. Those instate institutions were picked up after leaving HMD and sent to institutions administered by authorities in the region where the patient required hospitalization. The case in a veteran's hospital had served in the army following his release from HMD and had become eligible for government hospitalization. These patients represent about thirty per cent of the total number of cases studied.

Age and Sex

The following table presents the ages of these patients at the time they entered the hospital and their sex.

TABLE VI
AGE AT ADMISSION

Age	Male	Female	Total
17	5	4	9
16	3	2	5
15	2	-	2
14	2	2	4
10	1	-	1
Total	13	8	21

Their present ages now range from seventeen to thirty-two, representing from five to fifteen years of illness. Due to length of time and the inability to adjust, the outlook in all of these cases must be considered dismal.

Diagnosis, Prognosis and Treatment

The following table shows diagnosis by sex.

TABLE VII
DIAGNOSIS BY SEX

Diagnosis	Male	Female	Total
Dementia Praecox	8	5	13
Juvenile Paresis	1	1	2
Primary Behavior Disorder	1	1	2
Psychopathic Personality	1	-	1
Post-encephalitis	1	-	1
Psychosis with Mental Deficiency	1	-	1
Convulsive	-	1	1
Total	13	8	21

The prognoses in these cases included seven poor, seven guarded, two fair, three good and, in two cases, no prognoses were available. Eleven cases received intensive shock therapy and four of this group were lobotomized. The two paretics received fever treatment and anti-luetic therapy. The remaining eight cases received routine hospital and custodial care. Shock treatment, electro and/or insulin and also metrazol in the earlier cases, was administered to all praecoxes except one where the patient's improved spontaneously only to break down and enter another hospital. In the cases of the fair and good prognoses, some were largely contingent upon favorable home or convalescent conditions which were never available. Unfortunately this situation is quite general. Patients returning to or faced with the prospects of returning to the same set of circumstances in which they broke down often break down again or fail to improve. In this community as in most others there is no middle ground where a patient can ease the break between his hospitalization and his return home.

Personality and Reason for Admission

Seventeen of the children were of retiring, seclusive natures, while the other four were considered by their families to be of outgoing disposition. Twelve were considered docile youngsters while nine were of the temper tantrum, stubborn variety. Intensification of these patterns or change in personality were frequently given among reasons for admissions. In all cases inability to adjust at home or in school was a dominating factor. Impulsive, negativistic behavior was cited as predominating in fifteen cases, fearful and seclusive in two, sexual preoccupation in three, silly and noisy in one. Of the seventeen seclusive children, twelve were praecoxes, two were paretics, one was a psychopath, one a post-encephalitis and one a convulsive.

The outgoing personalities were two primary behavior disorders, one psychosis with mental deficiency and one hebephrenic praecox. Practically all of the cases presented hallucinated, delusional behavior. It must be stated here that the behavior and personality descriptions were derived chiefly from parents which can hardly be considered totally unbiased. Their reactions were colored by their own personalities. One retiring parent described his child as friendly and outgoing and when asked why, replied "he always says 'hello' when somebody says 'hello' to him". However, it was felt that the personality and behavior descriptions were fairly accurate because, in general, the descriptions coincided quite well with the general types of behavior and personality to be expected of the diagnoses rendered.

Familial Mental History and Home Situation

In eleven cases there was a history of mental illness within the family relationship and in ten the history was negative. Fourteen home situations were poor, while seven were fair. These statistics are, generally speaking, in keeping with the total statistic cited in Chapter II. There is little to indicate that familial mental illness is passed on while there is much on which to base the conjecture that poor home situations constitute a factory in breakdown.

Intelligence and Previous Health History

Twelve of the children were of average intelligence whereas nine were retarded. In seventeen instances health histories were essentially negative. The four positive histories included two congenital lues, one praecox with pathological deafness and one post-encephalitis who had had two severe attacks of scarlet fever. A rather high proportion of retarded

children in this chronic group could well lead us to believe that the fact of retardation may well be a complicating factor but there is no evidence which might influence us to surmise that it is a primary factor. The high preponderance of negative health histories is indicative of how small a percentage of mental illness is traceable to the organic. There is a great tendency in families to grasp at physical reasons for breakdown since this is naturally a much more acceptable basis to them personally and acts as a panacea to any guilt feeling which they may have. Many families give histories of skull fractures, concussions, infections, high fevers, etc., but few cases are medically attributable to physical trauma.

Number of Admissions and Present Condition

These twenty-one cases have had anywhere from one to ten admissions. Eight have never been able to leave the hospital after original commitment. Eight have been tried outside once. Three have tried five times, one six times and one has made the attempt on ten occasions. In practically all instances the home situations to which the children returned were so poor that adjustment would have been impossible. The child who has been in and out ten times has been lobotomized twice, is silly, bizarre and impulsive. He leaves the hospital at the insistence of his father who appears to be an older less exaggerated edition of his son but who has never has occasion to be adjudged clinically. Sixteen cases are improved and five have shown some improvement, two following lobotomy and one after intensive fever therapy. In general these patients are greatly deteriorated intellectually and their outlook for the future is poor.

Patients in Penal Institutions

At the time of the study, there were seven patients committed to penal or correctional institutions. Three are housed at Central State Hospital, division for the criminal insane at the state prison, Waupun, Wis.; was one in the Wisconsin State Industrial School; one was at the Wisconsin State Reformatory and one was in a federal penitentiary. Five of these children were released from the hospital, one escaped and one was transferred to a state institution as a nonresident, from which he later escaped with the help of his mother. In general, these were patients whose needs could not be met at HMD and were sent to this institution purely for the reason that there was no place to send them, all other attempts at control and rehabilitation having failed. These were the children who created disturbances at home, in foster homes, orphanages and schools.

Age and Sex

At admission, two were seventeen; two were fifteen; one, thirteen; one, eleven and one was nine. Their present age range is from sixteen to twenty-six, representing from six to nine years of known instability. All were male, which is in keeping with the overt manifestations which more frequently bring the male into conflict with the law.

Diagnosis, prognosis and Treatment

Three of these cases were primary behavior disorders; two were psychopaths; one was parietic and one a post-encephalitis. Three carried guarded prognoses and three were poor. In the other case no prognosis was available. From the diagnoses rendered, these are the categories in general which may be expected to conflict with the law. From the prognoses it is

clear that the outlook from the beginning was bleak. Treatment in these cases was routine as it was felt that the more intensive type of therapy would be of no benefit to these children. Only one shock treatment was given, after which the young patient escaped in his hospital gown, leaped over a fence but was returned a few days later. All of which leads us to wonder what these children are doing in an institution where the therapies designed for the mentally ill cannot benefit them. The one patient, the parietic, was transferred to a state institution as a non-resident to receive anti-luetic therapy. It was this patient whose luetic mother aided him in escaping from that institution.

Personality and Reason for Admission

Two were of a rather seclusive nature while five were of outgoing temperament. Stubbornness and temper were paramount characteristics in this group. Pyromania and stealing were cited as reasons for admission in five of the cases while impulsiveness and running away were given in the other two cases. In general, these were children of fiery, brooding, tempestuous natures openly at odds with society. Their behavior was assault upon a distasteful world in contrast to the retreat to the more satisfactory dream world so much in evidence among the group still hospitalized. Their very natures and activities are a prelude to disorganized criminal careers if a means to cure their town emotions cannot be found.

Familial Mental History and Home Situation

In four of the cases a history of familial mental illness was given and in three no such background was evidenced. In each case the home situation was deplorable. In one case both parents had been under observation

but never committed, another came from a line where mental illness existed on the paternal side; another was the illegitimate child of a committed mother; one boy had a retarded brother. All but one of the cases were from broken homes, five marked by separation, divorce and remarriage with a strong thread of strife and immorality in the homes. One father was deceased. In the instance where the parents remained together there was infinancial and emotional insecurity, lack of insight and unresolved sibling rivalry. The rather equal division of cases wherein mental illness is found within the families leads us to believe that there is little evidence to favor familial history as much of a factor in the child's hostile, aggressive attitude. On the other hand, with the total situation weighted to wretched home conditions, it would seem that disintegration of personality can and frequently does follow disintegration of the family, particularly in this anti-social group.

Intelligence and Previous Health History

Four of the cases studied were of average intelligence; two were borderline and one was superior. IQ's ranged from the borderline case with an IQ of 85 to the superior with a rating in excess of 110. Both followed a similar pattern of aimless criminal intent, neither seeming to be more organized or inspired than the other. In all cases, with the exception of the paretic and the post-encephalitis, previous health history was negative. In six cases families gave histories of head injuries and high fevers but in only one was there any evidence of damage to the cortex on the electro-encephalograph, this being in the case of the post-encephalitis. On the basis of this small segment of the criminally inclined it would appear that general intelligence had no bearing on behavior. It is also evident by the same

token that health history in general has little bearing on breakdown.

Number of Admissions and Last Condition Report

These patients were admitted anywhere from one to eleven times. Five had only one admission and were released in the hopes that more satisfactory arrangements would be made for them. One was transferred and one eloped from the hospital. The child with eleven admissions had escaped from the hospital many times, each time he returned being listed as an admission. The five were listed at the last recorded contact as unimproved while two had shown some improvement under supervision. The present situation would indicate that mental hospitalization had little beneficial effect. It is also clear that the two cases showing improvement did not hold this improvement. In fact it is entirely possible that, like many with the same diagnoses (one was a psychopath and one a primary behavior disorder) they were able to adjust in a closed institution, either to gain their own end, release, or because they were free from outside pressures.

Offenses of the Incarcerated

One of the primary behavior disorders is in a federal penitentiary for stealing from the mails. Another was sent to the state prison for stealing a car. Another is in the state reformatory for theft. Both psychopaths are in the state penitentiary for burglary. The post-encephalitis began by stealing bicycles, finally stole a car, left the scene of an accident and was sent to the state industrial school. He was released and returned for assault. The parietic was last known to be in a state industrial school, offence unknown. These overt, anti-social acts are in keeping with the diagnoses rendered and constitute the type of activity to be expected

in these cases.

Summary

Of the twenty-eight cases, representing about forty per cent of the totals, still institutionalized juveniles, twenty-one are in mental hospitals and seven are in penal institutions. Those in mental hospitals ranged in age from ten to seventeen at admission, current ages being from seventeen to thirty-two, representing from five to fifteen years of known illness. Sixty-two per cent were male and thirty-eight per cent female. Sixty-two per cent were schizophrenic, the other thirty-eight per cent being scattered in five different categories. Sixty-six per cent carried poor or guarded prognoses; twenty-four per cent were fair or good and, in ten per cent prognoses were available. Fifty-two per cent received intensive shock therapy and, in this group, there were four lobotomies performed. Eighty-one per cent of the hospitalized patients were of retiring, seclusive natures. Failure to adjust at school and at home dominated general reasons for admission. Hallucinated, delusional behavior marked practically all of the cases. Familial history of mental illness was present in just about half of the cases while sixty-six per cent of the home situations were downright poor and thirty-three per cent were only fair. Fifty-seven per cent were of average intelligence whereas forty-three per cent were retarded. Eighty-one per cent of the children had negative health histories whereas only nineteen per cent had physical findings on which breakdown might be based. Of the cases studied herein, thirty-eight per cent have never been well enough to leave the hospital. Another thirty-eight per cent have been tried once outside and were unable to adjust. The remaining twenty-four percent have attempted to live outside the hospital anywhere from five to ten times without success.

Seventy-six percent of the cases are considered unimproved, twenty-four per cent improved following lobotomy, shock, fever therapy and intensive care.

Of the seven patients in penal and correctional institutions three are in the criminal insane division of the state penitentiary; two are in industrial schools; one is in a federal penitentiary and one is in a reformatory. Their admission ages ranged from nine to seventeen and their current ages from sixteen to twenty-six, representing from six to nine years of known instability. Diagnostically they include three primary behavior disorders, two psychopaths, one paretic and one post-encephalitis with three poor prognoses, three guarded and one unavailable. The personality patterns of five was considered outgoing, two rather seclusive with stubbornness and temper outstanding characteristics. Reasons for admission included pyromania and stealing in five cases, impulsiveness and running away in two. In general only routine care and institutionalization was afforded these patients. The cases were about equally divided as regards familial mental illness and the home situation was deplorable in every case. All were male. Four children were of average intelligence, two borderline and one superior. Previous health history was negative in five out of the seven cases. Five had only one admission; one eloped from the institution and one was transferred. Five were listed at last record contact as unimproved while two had shown some improvement. The offenses of the incarcerated included two for burglary, one for contributing to the delinquency of a minor and stealing a car, another for stealing a car, another for theft and assault, another for stealing a car and leaving the scene of an accident while the offense of the seventh was unknown.

It is clear from an examination of the facts that the individuals, still receiving inside care, have not found the answer to their problem through the hospitalization afforded them. It would be inaccurate to say that they did not receive good care or that they derived no benefit because all of the facilities of this large progressive mental institution were available to them. Also it would be pure conjecture to say that they would have improved or been cured in another setting. Moreover, the institution itself does not contend that it is equipped to meet the needs of children. In general, when ideal facilities or facilities approaching the ideal are provided for children, they should and do in many cases respond, at least to some extent. These ideal facilities would, of course, include a setting for convalescence as well as suitable conditions following release.

CHAPTER III

PATIENTS LIVING OUTSIDE OF INSTITUTIONS

Introduction.

This chapter will include the cases which are presently living outside of institutions. These cases will be examined as to age and sex, diagnosis and prognosis, treatment, personality and reason for admission, familial mental history and previous health history, number of admissions and last known condition, marriage, economic and social status.

Patients Outside of Institutions.

At the time of this study there were forty-one cases living outside of institutions. This figure does not represent cured cases but cases which have been able to adjust in one way or another for protracted periods or even short intervals. Many of these have received maximum hospitalization and others must go, if they are at all able, so that space can be made for the more acute incoming population. The ages of the males and females at admission are best illustrated by the following table.

TABLE VIII
AGE AND SEX

Age	Male	Female	Total
9	1	-	1
11	3	-	3
13	2	-	2
14	3	4	7
15	4	2	6
16	3	8	11
17	8	5	13
Total	24	19	43

Of the forty-three patients, forty-one are still living. One boy admitted at eleven died six months later of Schilder's Disease and broncho-pneumonia. A girl admitted at seventeen was also organic, a post-encephalitis, and died at thirty-one of a coronary occlusion. Twenty-three males and eighteen females are residing outside. This means that about fifty-two per cent of the total male population admitted is currently able to live outside whereas about seventy-two per cent of the females are out. The difference seems to lie largely in the individuals discussed in the previous chapter who are in penal institutions and who are all male, representing about sixteen per cent of the living male population. Eighty-six per cent of the cases are between the ages of fourteen and seventeen inclusive. It is interesting to note that they were almost equally divided as to sex, eighteen females, nineteen males. It would

appear from these figures that, in these adolescent years, one sex is quite a likely to break down as the other, the extra burden of adolescence being placed on an already crumbling personality structure.

Diagnosis, Prognosis and Treatment.

Henceforward in this study we will be concerned with the forty-one living cases, eliminating the two organic psychoses which have died. The following table will serve to illustrate diagnoses by sex of the patients.

TABLE IX
DIAGNOSIS BY SEX

Diagnosis	Male	Female	Total
Dementia Praecox	11	9	20
Mental Deficiency	-	2	2
Psychoneurosis	1	1	2
Primary Behavior Disorder	2	1	3
Psychopathic Personality	3	-	3
Manic Depressive	-	3	3
Convulsive	2	0	2
Undiagnosed Psychosis	2	0	2
Post-encephalitis	1	0	1
Without Psychosis	1	2	3
Total	23	18	41

On the basis of fifty-six per cent male and forty-four per cent female admissions, it is to be noted that the praecoxes are equally divided.

The primary behavior disorders are represented by two males to one female whereas the psychopaths are confined to the males. The manics are all female. This would seem to substantiate our contention that schizophrenia is impartial as to sex whereas the behavior disorders and psychopathy favor the male. The manic depressive psychosis appears to attack the females in this group. A further study along these lines to consider the total manic depressive population of a hospital as well as the psychopaths and the primary behavior disorders might be interesting. The following table indicates prognosis according to sex.

TABLE X
PROGNOSIS ACCORDING TO SEX

Prognosis	Male	Female	Total
Good	3	5	8
Fair	1	2	3
Guarded	6	3	9
Poor	7	3	10
None	6	5	11
Total	23	18	41

The female population in general seems to carry a somewhat more favorable prognosis than the male. Later in the study we will consider the adjustment of these individuals. Of these patients shock was administered to fifteen cases, to eleven praecoxes, one psychoneurotic, one psychotic mental defect with a psychotic episode. Lobotomy was performed in one case, a male praecox. It is to be noted that only eleven out of twenty praecoxes received

radical treatment. In the other cases it was precluded by health condition and by families refusing consent or rendered unnecessary by spontaneous improvement under general care.

Personality and Reason for Admission.

Although many personality descriptions were admitted to the records the types in general seemed to divide into four distinct categories, namely as follows:

TABLE XI
PERSONALITY PATTERNS

Pattern	Number
Seclusive and docile	11
Seclusive and tempestuous	9
Friendly and docile	12
Friendly and tempestuous	9
Total	41

The children characterized roughly as belonging to the seclusive, docile group had accompanying traits in some instances of shyness, lack of confidence, and hypersensitivity. In the seclusive and tempestuous category we find accompanying attributes of stubbornness and hostility. The third group comprised the friendly, docile type but the writer feels from an examination of the records that de-emphasis must be placed on the term "friendly" as placing these cases in a completely out-going category as shyness appeared in many of the cases as well as lack of self-confidence. The family interpretation of the

word "friendly" in many instances meant that the child was not anti-social or completely asocial. The fourth division, the friendly tempestuous type, had much in their histories disclosing hostility and egocentricity. The vast majority of these cases were basically egocentric either in a hostile, aggressive manner or in a shy, retreating manner. None of them presented a history of what, by any standards, might be called a completely normal, well-adjusted child. Inability to adjust both at home and at school formed a blanket complaint.

In the docile and seclusive group, reasons for admission were in the main complaints of hallucinated, delusional, impulsive behavior, with a goodly portion of baseless somatic complaints, two cases of sex delinquency, two of suicidal intent, two of compulsive washing and feelings of personal uncleanness. This was a threatened, fearful group. Of the tempestuous, seclusive children complaints covered to a lesser degree hallucinations and delusions. Convulsions, belligerence, stealing, sadism, sex delinquency, threats to kill parents and delusions of personal body odor were given as reasons for admission. These were hostile, angry children. The friendly docile children were largely admitted (as were the seclusive dociles) because of hallucinations and delusions, impulsive behavior, somatic complaints, suicidal threats and compulsive cleanliness. This would lead one to believe that they belong actually more to the seclusive than to a truly friendly temperament. Of the friendly tempestuous personalities hallucinations and delusions were in the minority as reasons for admission. In the ascendancy were ~~scandalous~~ ^{sexual} threats to kill parents, impulsiveness, truancy, suicidal intent and stealing. This group in general seemed to be at open war with things as they are.



Familial Mental History and Home Situation.

In thirteen of the cases there was a direct history of mental illness in the family, meaning that either or both parents were psychotic or borderline in seven cases there was a history in either the maternal or paternal line and in twenty-one cases there was no definite history of derangement. The division between those with familial mental illness and those without is almost equally divided. However, in some cases it is fair to believe that certain facts have been concealed or that mental illness was not recognized as such. On the other hand, an illegitimate daughter of a feeble-minded, psychotic mother was found to be without psychosis and of good intelligence despite her erratic behavior. In this group the home situations were poor and in many cases deplorable, thirty to be exact. Only ten could be remotely considered fair and one satisfactory, this latter situation being only sparsely covered in the record. In eleven instances the child was the victim of a broken home on the basis of death, divorce, separation or illegitimacy. In these histories rejection or overprotection, the indirect form of rejection, were listed in twenty instances sibling rivalry in eleven, alcoholism in five, rigidity in four, marital strife and flagrant inadequacy in about half of the cases, outright immorality known to the child in six. In many cases it was found that one parent was outright rejecting with the other protecting, causing a confused and impossible situation for the child in which there was no room for healthy emotional growth. In other instances, treatment and convalescence were hampered by emotionally disturbed parents. One uncommitted paranoid mother refused to sign shock consent. She was the mother who, when discussing auditory hallucinations said, upon the writer's denial of hearing voices, "Maybe your hearing isn't as good

as my daughter's and mine". This mother, who insisted on taking her daughter home, was recently murdered, stabbed seven times with a butcher knife by the girl who did it "because she looks so pretty when she is asleep". The father, a kind, long-suffering, inadequate individual signed the girl's release from the hospital. In ten instances these children were first generation Americans, raised according to the customs and standards of their foreign-born parents. However, there is no evidence that this was any determining factor in breakdown other than the additional conflict between old and new world customs, and the parents' failure to recognize same. In practically every one of the forty-one cases there was an appalling lack of insight on the part of the parents.

Intelligence and Previous Health History.

Thirty-one of these children were of average intelligence, seven were retarded and three were superior. The vast majority, seventy-five per cent were of the average rank and file of intelligence. The adjustments seem to have nothing to do with the intelligence of the individuals, all categories making good and poor adjustments. Although many of these children had had serious illnesses, including severe scarlet fever, healed tuberculosis, skull fractures, pneumonia, etc., actual physical findings were positive in only three of the living group, two convulsives and a post-encephalitis. This represents negative findings in ninety-three per cent of the group. Despite the tendency to base mental illness on a physical basis, the evidence is preponderantly against this premise.

Number of Admissions and Last Known Condition

In the group under consideration, twenty-two have had only one adm-

mission, ten have had two, three were admitted three times and four came four times, while the two remaining were admitted six and seven times respectively. The last known condition from the record was considered improved in twenty-nine cases, unimproved in four, recovered in six and two were found to be nonpsychotic. The six cases found recovered have never re-entered the hospital and five are making good adjustments, the adjustment of the sixth being unknown but probably adequate as no inquiry has been made regarding her. Of the twenty-nine improved cases, twelve did not return whereas seventeen returned from two to seven times. In general, the adjustment of those in the improved group varied little whether they had been in the hospital once or several times. It appears from the facts that the improved cases did not fulfill the promise which they had shown upon leaving the hospital, either deteriorating or failing to gain improvement. This was probably due largely to the impossible environments which in general it was necessary for them to return. Adjustment of all of these individuals will be discussed at length later in this chapter.

Marriage Status.

In an effort to determine objectively the marital adjustment of the nineteen patients who married, each case was examined as to length of the union, evidences of friction or congeniality in the marriage as gleaned from the records, from the patients' families and, in many instances, from the patients themselves. It was found that the average length of time of the unions was two years. Therefore, a positive credit was given to those marriages which have exceeded this figure. Positive and negative credits were given in cases of harmonious and dissident marriages respectively. Where one

or more positive weights occurred the marriage was considered satisfactory, one or more negatives being considered unsatisfactory. Five cases were making very good adjustments with three positives to their credit and seven were adequate with one positive. One was deemed very unsatisfactory with separation and failure to care for his child, four were unsatisfactory with divorce, separation and threatened separation indicated. The following table will serve to indicate the number and sex of patients who have married and the type of adjustment which they are making.

TABLE XII
MARRIAGE ADJUSTMENT

Adjustment	Male	Female	Total
Satisfactory	5	8	13
Unsatisfactory	3	2	5
Unknown	1	-	1
Total	9	10	19

In this breakdown, patients having children and showing a positive attitude toward them were given credit as it was felt that the patient should be commended because the support and supervision of children is an additional responsibility for these individuals to bear. All in all, the findings can be considered reasonably good in general, considering the handicaps. What does seem vitally important is that the patient's spouse have patience and understanding, realization of and tolerance for the patient's short-comings, which, perhaps, would also cover the marriages of normal individuals which often

break down because of the lack of similar attributes. It is encouraging to note that, in none of the cases to date, has it been necessary for a patient to return to the hospital because of breakdown at the birth of a child. In fact, a psychotic mental defect who is now pregnant and who was in the hospital four times, is presently holding her most sustained release from the institution. The same applies to a praecox with four children who had previously had three admissions to the hospital. In fact, although adjustments between the sexes is about equal, the women have four good adjustments to two for the men and three of these women have had two or more children. A brief resume by case will be found later in this chapter.

Adjustment to the Single State.

In view of the fact that an attempt is being made to secure an over-all evaluation of the adjustment of these patients, it is important to the study to determine the adjustment which the unattached individuals have made in the sexual area. Although information was sparse, it was possible to divide these cases into two categories by which they could be examined, namely, 1) those with sex offences or promiscuity, with negative weights assigned and 2) those with normal sex interest or lack of same, with positive and negative weights assigned respectively. One positive indicated satisfactory adjustment and one negative revealed unsatisfactory adjustment. The following table illustrates the adjustment shown.

TABLE XIII
TABLE OF SEXUAL ADJUSTMENT

Adjustment	Male	Female	Total
Satisfactory	5	2	7
Unsatisfactory	6	4	10
Unknown	3	2	5
Total	14	8	22

The above information was derived from the record, from police officers and from the families of the patients. A more detailed examination will be found in the case summaries later in this chapter.

Employment Status.

Of interest to us also is the employment status of the men and the unattached females residing outside. The following table will serve to illustrate this point. As is well known, working is an integral part of life and the ability and initiative to work is an important facet in the mental well-being of an individual.

TABLE IV
EMPLOYMENT ADJUSTMENT

Adjustment	Male	Female	Total
Sustained	11	3	14
Intermittent	9	1	10
Unemployed	2	2	4
Unknown	1	3	4
Total	23	9	32

In this table we are concerned only with unattached women since many of the girls are married and engaged in homemaking and raising a family. The average age of these single women is twenty-seven, ranging from eighteen to thirty-one inclusive. The average for the men is twenty-five, ranging from eighteen to thirty inclusive. An examination by case will be contained in the summaries contained at the end of this chapter.

Social Adjustment.

Of primary importance also is the ability of the patient to socialize in harmony with his fellow-men. To determine his social adjustment, various factors of behavior involving inter-action with other human beings were taken into consideration. Those involving negative weights were asocial and anti-social behavior. Positive weights were designated where the patients seemed to relate quite well to others. The following table illustrates this point.

TABLE XV

SOCIAL ADJUSTMENT

Adjustment	Male	Female	Total
Satisfactory	6	6	12
Unsatisfactory	12	10	22
Unknown	5	2	7
Total	23	18	41

Unsatisfactory adjustments were largely in the area of the praecoxes and the behavior disorders which diagnoses comprised sixty-four per cent of the unsatisfactory adjustments. Details will be found in the case summaries later in the chapter.

Total Adjustment.

Of particular interest to us is the total adjustment which the patient has been able to make. This includes all phases of his ability to adjust in a normal world such as marriage, sex, employment¹, social intercourse and ability to stay out of difficulty. Because of the intangibles involved this breakdown is by nature hypothetical. To determine this total adjustment, each case was examined and negative and positive weights assigned to the patient in the areas which we have analyzed in the preceding pages. Two or more positive ratings constituted good adjustment, one indicated fair adjustment and no positive ratings showed poor adjustment. The following table will indicate the caliber of total adjustment which the research would indicate.

TABLE XVI

TOTAL ADJUSTMENT BY DIAGNOSIS

Diagnosis	Adjustment				
	Good	Fair	Poor	Unknown	Total
Dementia Praecox	7	2	8	3	20
Manic Depressive	3	-	-	-	3
Without Psychosis	1	1	-	1	3
Primary Behavior Disorder	1	-	2	-	3
Psychopathic Personality	1	-	1	1	3

1 Successful home maintenance and successful child raising in the event there are children, has been considered as satisfactory employment in the cases of the married women so that a proper weighting can be established in this category.

TABLE XVI (Continued)
TOTAL ADJUSTMENT BY DIAGNOSIS

Diagnosis	Adjustment				
	Good	Fair	Poor	Unknown	Total
Psychoneurosis	2	2	-	-	2
Convulsive	1	-	1	-	2
Undiagnosed Psychosis	1	1	-	-	2
Post-Encephalitis	1	-	-	-	2
Mental Deficiency	-	1	1	-	1
Total	18	5	13	5	41

For a rather more conclusive picture let us examine these uninstitutionalized cases briefly by summary as to information secured from the record, collateral and home visits, police reports and reports from other agencies or organizations.

Case I. Beulah B., 22, praecox, was admitted at sixteen and it was felt that her prognosis was good and her condition had improved when she left the hospital. However, it was necessary for her to return to a widowed father toward whom she was ambivalent. He had always favored the patient's only sibling, an older sister, whereas the deceased mother had favored the patient. She has been outside six years, has been married about two, drinks and makes lengthy visits to relatives who do not want and cannot afford her. Socialization is parasitic by nature and her bewildered husband has been supplying her beyond his means with the luxuries which her egocentricity demands. She is threatening to divorce him. Prior to marriage she worked briefly. Her total adjustment is obviously poor.

Case II. George G., 20, psychoneurosis, was admitted at 14 from an adequate home and the prognosis was good. He had recovered when he left the hospital. He has been married a few months and is apparently happy. He has been in the Army Air Corps three years, likes it and has signed up for three more years. He mingles with people and his total adjustment seems good.

Case III. Dorothy D., 22, psychotic mental defect with a poor prognosis was 16 at admission and was improved upon release. Her home situation was poor, the entire family being of borderline intelligence and low standards. Both parents were inadequate and the father was alcoholic. She has been married about a year, is pregnant, silly and child-like, pre-occupied with sex but seems to be making an adequate adjustment to a simple patient husband. She was never able to sustain employment. Her socialization was of a low level and she was unable to get along with people. Her total adjustment is only fair.

Case IV. Millicent M., 20, primary behavior disorder, was admitted at 14 with a good prognosis. She had improved when she left the hospital but returned to an upper-middle class home where a younger sister was favored. The father appeared outright rejecting with the mother over-protective. Both parents were college graduates. She has been in various special schools and hospitals and has been unable either to sustain education or employment. She has shown no particular interest in the opposite sex but develops violent "crushes" on older women, including teachers and hospital personnel. She recently ran away from her home in the west, returned to Milwaukee and attempted to move in with a woman who was an assistant supervisor at the hospital. She has also attempted suicide. Her socialization has been of a negative variety and her adjustment

is poor.

Case V. Martin M., 23, psychopath, no prognosis given, was admitted at 17 and was improved when he left the hospital. He returned to a home situation where there was much domestic difficulty because of an inadequate father and a domineering mother. He has been married about two years to a lame girl who is apparently patient and understanding. They have one child and he has held employment as a lay-out man for almost a year. There seems to be little socialization. Adjustment, however, is quite good in general.

Case VI. John J., 18, primary behavior disorder with a guarded prognosis, was admitted at 11 and was improved upon release. His home life was poor with a father who drank and associated with other women. His mother was unstable and inadequate and died when John was 14. He gets along well with an understanding step-mother. He is on probation for driving a car without the owner's consent but his probation officer advises that he has normal interest in the opposite sex, is making a good adjustment and has been employed as a machinist's helper for over a year. He socializes and is well liked by his fellow workers. Adjustment is quite good.

Case VII. Alice A., 21, praecox with a good prognosis, was admitted at 14 and left in an improved condition. Her parents adhered to old-world discipline were rigid and the father favored an older male sibling. She has been married happily for three years, has two children and is a good housekeeper and mother. She had not been employed prior to marriage. Socialization is adequate and total adjustment is good.

Case VIII. Doris D., 27, psychoneurosis with a good prognosis, was admitted at 17 and was improved upon release. Home life was unhappy. Her mother

worked, failed to supervise the children and the patient was jealous of a happy, favored younger sister. Later she lived with an understanding aunt who helped her greatly. She has been married two years to a well-adjusted mate, works part-time but remains somewhat nervous and high strung. Socialization is adequate and adjustment is good.

Case IX. Joseph J., 27, praecox with a guarded prognosis, was admitted at 17 and had improved when he left. However, he refused for years to leave the hospital, was sarcastic and demanding, considered himself a genius and advertised himself in the paper as such. (Actually his IQ did range to about 140). He returned to the home of a rigid father who refused to face the situation and a mother completely under the father's domination. He had only contempt for his parents. He has exhibited no interest in the opposite sex, sits idly at home and has never sustained even unskilled employment more than a few weeks. He is seclusive and adjustment is poor.

Case X. Catherine C., 24, without psychosis and with a guarded prognosis, was 16 at admission and left improved. She chose to transfer to the Industrial School in order to complete her high school education and did so. She was the illegitimate child of a feeble minded, psychotic mother who rejected her after the patient had sought her out. She was raised in institutions. She has had one illegitimate child, has wandered around the country and has failed to sustain employment. She has been married less than a year to a man who has accepted her child. He appears to be able to supervise her and she is happy with him. Her socialization has been of the negative variety and adjustment seems no more than fair.

Case XI. Gerald G., 27, lobotomized praecox, prognosis guarded, was 17 at

admission and left the hospital improved. His home situation was poor with an unstable, dominating, over-protective mother, and his father takes little interest and both foreign-born parents are poorly assimilated. He exhibits no interest in the opposite sex, does nothing except "help mother" and remains seclusive. Adjustment has been poor.

Case XII. Ned N., 22, psychopath with a guarded prognosis, was admitted at 13 and left the hospital improved. He was rejected by both parents after the birth of a brother six years after his own birth, having been over-protected up to that time. His mother was weak, his father punitive and he was raised largely by aged grand-parents. He was married a few months, divorced and is again seeing his ex-wife. At the time of their elopement she assisted him in stealing a car. Their honeymoon was spent in jail and since their divorce she has attempted to bribe a guard to release him from jail where he was serving time for stealing. He has had sex offences and a poor employment record and his socialization is of a negative type. Adjustment is poor.

Case XIII. Walter W., 24, praecox with a poor prognosis, was admitted at 15 and left the hospital improved. His father deserted when the patient was five and his mother worked, leaving him much to his own devices. He works occasionally as a musician, has been married a few months and remains in his mother's home. Socialization is negative and adjustment poor.

Case XIV. Anna A., 27, praecox with a poor prognosis, was admitted at 16 and left the hospital improved. Her home situation was poor with a kindly, ineffectual father and an extremely psychotic uncommitted mother. She had one sibling, an older brother, to whom she was very attached, but he escaped this poor home environment and is making a good adjustment. She has no interest in

the opposite sex, has not sustained employment, is seclusive and, in the early months of 1953, murdered her mother. Adjustment was very poor.

Case XV. Ella E., 24, praecox, prognosis unknown, was admitted at 16 and remained unimproved to go to a private sanitarium. Her father was rigid and her mother domineering and over-protective. The father had a hobby, pornographic pictures, which he left about the house and the family had no social contacts. The patient has been married four years, has two children and takes good care of her home and family. She did not work prior to marriage. Socialization is adequate and adjustment is good.

Case XVI. Clement C., 21, praecox with a poor prognosis, left the hospital improved. The mother who died when the patient was ten had spoiled him. His father, a kindly man who was steadily employed was unable to supervise him. The patient exhibits no interest in the opposite sex, fails to hold employment and is seclusive. His adjustment is poor.

Case XVII. Dan D., 21, praecox with a poor prognosis, was admitted at 14 and left the hospital improved. His parents were inadequate, the home was filthy and unsupervised and there was a long record of delinquency and truancy among the siblings. He has been married successfully for a year and has a hydrocephalic child who is dying in an institution. He has been working steadily for about a year as a milkman. He apparently socializes little and is nervous but his adjustment is quite good.

Case XVIII. Daisy D., 26, mental defect with a fair prognosis, was admitted at 16 and left improved. She resides with a depressed, widowed mother who has always worked and the home atmosphere is gloomy. She has worked spasmodically at unskilled labor and is illegitimately pregnant, claiming this condition was

forced upon her by a man who threatened to kill her if she did not accede to his wishes. Socialization is of a negative variety and adjustment is poor.

Case XIX. Harry H., 28, praecox with a fair prognosis, was admitted at 17 and left recovered. He has exhibited normal sex interest and was engaged at one time. He has been steadily employed for ten years as a brewery laborer and socializes to some extent. Adjustment has been good.

Case XX. August A., 22, praecox with a poor prognosis, was admitted at 17 and left improved. His mother was nervous and his father lacked insight. The patient felt no closeness to either parent and was attached to an elderly paternal grandmother. He has exhibited no sex abnormalities, socializes with girls, is a junior mathematics student in a university and works part-time to defray expenses. Socialization is adequate and adjustment is good.

Case XXI. Edward E., 27, convulsive with a poor prognosis, was admitted at 16 and left the hospital unimproved. His home situation was fair with the exception of an overprotective mother. He has exhibited no interest in the opposite sex, has been unable to work and remains housebound and seclusive. His adjustment is poor.

Case XXII. Gordon G., 28, convulsive with a good prognosis, was admitted at 17 and released as recovered from the episode. Aside from an over-protective mother, home life was average. He has normal sex interests, has been employed at unskilled labor for ten years and socializes to some extent. Adjustment has been good.

Case XXIII. May M., 28, praecox with a guarded prognosis, was admitted at 15 and left improved. Her parents were dull and the father, a heavy drinker, was a poor provider. There was unresolved sibling rivalry with an older sister.

The patient was married several years to a kind, understanding mate who died. She worked briefly and has now been married again for about a year. Socialization seems adequate and adjustment is quite good.

Case XXIV. Helen H., 31, manic, no prognosis given, was admitted at 16 and left improved. Her foreign-born parents were well-adjusted to American standards and were sympathetic but lacked insight. She has had one illegitimate child whom she has kept and to whom she is devoted. She has worked steadily for the past few years as a file clerk and socializes. Adjustment, in general has been quite good recently.

Case XXV. Paul P., 20, praecox with a poor prognosis, was admitted at 15 and left improved. This patient's mother was over-protective, his father inconsistent. Both parents worked long hours and left Paul to the supervision of a slightly older sister. He has exhibited no sexual interest. He has worked steadily two years doing wiring but remains seclusive. Adjustment is fair.

Case XXVI. Allan A., 30, praecox, no prognosis given, was admitted at 17 and left improved. The home situation was poor with constant marital strife, precarious finances and lack of insight. The patient was married for about a year, attempted to deliver his own child, threatened to kill his wife and she was forced to flee for her life. His employment was intermittent and his socialization was negative. He accepted no responsibility for his child and has since been in another mental hospital. Adjustment has been very poor.

Case XXVII. Hilda H., 28, praecox with a good prognosis, was admitted at 14 and left improved. Her mother was over-protective. She has moved to California with her parents and attempts at contact have failed. Present status is

unknown.

Case XXVIII. Ivan I., 27, praecox with a good prognosis was admitted at 15 and left improved. His parents were quiet, backward people with no insight. He was married about a year ago and the couple remains with his parents. Marital and social adjustment are unavailable but he evidently does not sustain employment. Total adjustment is unknown but is probably poor.

Case XXIX. Edmund E., 23, primary behavior disorder with a poor prognosis, was admitted at 11 and left unimproved to return to the Juvenile Court. Home situation was poor with an over-protective mother. He had two brothers in the Industrial School and a delinquent sister. He has exhibited sexual pre-occupation and has been promiscuous. He is on probation and refuses to work and socialization is negative. Re-commitment has been recommended but his family is afraid to follow through as he has threatened to kill them and others and is potentially homicidal. Adjustment is poor.

Case XXX. Harold H., 29, praecox with a guarded prognosis, was admitted at 17 and released as improved. His parents lacked insight, The home was well kept and comfortable. Sibling relationship was good. The patient has been married five years and has two children. He has been operating a small auto repair shop with a partner for several years and is doing quite well. Socialization is adequate and adjustment is good.

Case XXXI. Viola V., 22, manic with a fair prognosis, entered the hospital at 17 and left recovered. Her parents were divorced and her step-father, with whom she and her mother lived, was a heavy drinker and abusive toward the mother. Sibling relationship was good. The mother is now divorced and she and the patient live together. She has normal interest in the opposite sex,

has been employed one and one-half years in a factory and socializes adequately. Adjustment is good.

Case XXXII. Janice J., 31, praecox with a poor prognosis, was admitted at 14 and left improved. The family lived in a poor area and the father was ill, nervous and a poor provider. Both parents were dull and supervision was poor. The patient has been married five years and has four children, including twins toward whom she is kindly disposed. Housekeeping is poor, affect somewhat flattened and socialization poor. Adjustment is only fair.

Case XXXIII. Ray R., 27, undiagnosed psychosis, no prognosis available, was admitted at 13 and released as unimproved for commitment to the Industrial School. He was an illegitimate child with a stepfather. His mother and stepfather favored his legitimate siblings and the mother's morals were questionable. She encouraged the patient to leave home and he frequently ran away as a child, claiming he was seeking work to earn money to help his mother and the family. He has shown no sexual abnormalities but his employment history has been poor and his social adjustment is unknown. Total adjustment has probably been no more than fair.

Case XXXIV. Cora C., 31, without psychosis, prognosis good, entered the hospital at 17 and left recovered. The patient preferred her father who was divorced from the mother but she lived with her mother and stepfather. The mother had lived with the stepfather several years before their marriage, a situation which was known to the patient. Her mother and stepfather drank heavily and he beat the patient. Cora was admitted as a sex delinquent, guilty of fraternizing with older men and negroes. She has been married nine years, has three children and is a good wife and mother. She finished school and

worked well as a switchboard operator prior to marriage. Socialization is adequate and adjustment is good.

Case XXXV. Lawrence L., 23, undiagnosed psychosis with a guarded prognosis, entered the hospital at 15 and left improved. His parents were uncooperative and dull. His mother was mannish and worked constantly, failing to supervise the children. His father fraternized with other women. He exhibits no sexual abnormalities, is in the Army and has recently returned from overseas where he served two years. The degree and type of his socialization is unknown but adjustment seems reasonably good.

Case XXXVI. Avis A., 31, manic, no prognosis available, was admitted at 17 and left improved. Home situation was only fair. Her parents maintained their old world customs, spoke only Italian and remained aliens. She has normal interest in men. She cares for an invalid mother and the household and socializes to some extent. Adjustment is quite good.

Case XXXVII. Victor V., 29, psychopath, prognosis unknown, came to the hospital from the Detention Home at 16 and was found not psychotic. His behavior improved and he was returned to the Detention Home. His parents were divorced and his mother was a woman of poor morals. He endeavored to assume a father role and his mother claimed he made sexual advances toward her. The city directory lists him as working as an office clerk and as being married but details were unavailable and total adjustment is unknown.

Case XXXVIII. William W., 23, post-encephalitis, prognosis unknown, was admitted at nine years of age and left improved. His mother is married for the third time and was a mental patient at one time. His step-father was rigid and his mother over-protective. He has attended college, is now a

sophomore and has worked part-time to defray expenses. His sex interests are normal. He is sociable and active in boy scout work but remains overactive. Adjustment is reasonably good.

Case XXXIX. Gilbert G., 30, without psychosis, prognosis unknown, entered the hospital at 16 and was found to be non-psychotic. He improved in behavior and he was discharged to the Juvenile Court. His parents were inadequate with his mother syphilitic and his father alcoholic. No direct contact could be established but the city directory lists him as single and working as a caster. Adjustment is unknown.

Case L. Clara C., 29, praecox, prognosis unavailable, was 15 at admission and left recovered. Her father was a barber with sparse employment and her mother was a registered nurse who seemed nervous and frustrated. All attempts to establish contact failed and adjustment is unknown.

Case LI. Deborah D., 28, praecox with a guarded prognosis, was admitted at 16 and left improved. Her mother was immoral and on probation and her father deserted. These facts were known to the patient. There was much delinquency among the siblings and the patient was also a sex delinquent. She was married briefly and separated and her employment record was poor. Her socialization is of a negative variety. Adjustment may be considered poor.

The overall picture is quite good because over half of the patients seem to be making good and fair adjustments. Also those in the unknown group are probably making at least some sort of satisfactory adjustment because there have been no inquiries from other hospitals or institutions. The praecoxes remain divided about half and half. This is a somewhat better percentage than the writer expected to find but the fact remains that about half of

these individuals are unable to lead any sort of normal, productive lives. It is interesting to speculate what further treatment, including intensive psychotherapy and satisfactory convalescent conditions, might have accomplished. It is also only fair to state that the writer's opinions may have been somewhat colored by what may and what may not be expected from these patients but an attempt was made to judge them impartially.

Summary

Forty-one cases, representing about sixty per cent of the total are currently residing outside of institutions. At the time of their admissions, their ages ranged from 9 to 17 with 86 per cent in the 14 to 17 inclusive group, almost equally divided as to sex. A total of 22 males and 19 females are represented. The preponderance of males seems to lie in the behavior groups which come into conflict with the law. In the schizophrenic group, which comprises about 50 per cent of the diagnoses, males and females, on a percentage basis, were equally divided.

In general the prognoses in the cases of the females were somewhat better than in the male population, five females carrying good prognoses to four male, although the male population exceeded that of the female. It was felt that this may be because of the essential nature of the female herself who does not bring herself so forcibly to the attention of the public and of whom less is actually expected as far as making her own living in the world is concerned.

The personalities of these patients can be roughly divided into four groups, the seclusive, docile; the seclusive, tempestuous; the friendly, docile; and the friendly, tempestuous. These groups represented 27 per cent,

22 per cent, 29 per cent and 22 per cent of the population respectively. Reasons for admission of both docile groups were preponderantly those of hallucinated, delusional behavior. In both tempestuous groups anti-social behavior such as belligerence, stealing, pyromania, threats to kill, etc., were in the ascendency.

Familial history of mental illness was present in half of the cases and half contained no such history. In only two of the cases could the home situation be considered even remotely adequate. Twenty-seven per cent were victims of broken homes. Marital strife, flagrant immorality, rejection, unresolved sibling rivalry and alcoholism were represented in the other cases. Insight was lacking in practically all instances.

Seventy-five per cent of these children had average intelligence, with only seven retarded and three superior. Ninety-three per cent had negative physical findings.

Slightly over half of the patients had only one admission to the hospital. Half of the remainder had two admissions while the others returned from three to seven times. Nine cases were considered improved, four unimproved, six recovered and two non-psychotic. The recovered group has never returned. Of the improved group twelve did not return whereas it was necessary for seventeen to come back for further treatment. The unimproved cases were released to other institutions or agencies.

Nineteen patients have married, nine men and ten women, with the average age twenty-five, ranging from nineteen to thirty-one. Seven men and nine women remain married, one male and one female are separated and one male is divorced. Half of the marriages have been of one year's duration or less

and the others have endured from two to nine years. Thirteen of the group are making a satisfactory adjustment and five are unsatisfactory.

By examination of the unmarried males and females, it was found that fourteen were making a satisfactory sex adjustment and eight were not.

Examining the employment status of the twenty-three males and nine unattached females, we find eleven men sustaining employment, nine working intermittently, two unemployed and the status of one unknown. Of the women three are sustaining employment, one is working intermittently, two are unemployed and in three instances the status is unknown. About half of the men are known to be sustaining employment and also about one third of the women although the larger percentage of the unknown status in the female group could well bring their percentage higher.

The patients were considered on the basis of their interaction with their fellow-men and it was found that twelve are adjusting satisfactorily and twenty-two are not.

Regarding the over-all adjustment of these individuals, comprising all factors including marital adjustment, employment, and social intercourse, it was found that eighteen are making good adjustments, five, fair and thirteen are poor. The status of five is unknown. Half of the cases are making a satisfactory adjustment. About fifty per cent are praecoxes and half of them are adjusting quite satisfactory.

It is interesting to note that sixty per cent have been able to remain out of the hospital for protracted periods. This is higher than might be expected, but the pressure for hospital space and the reluctance to return the patient are also factors because many of them are making no more than

marginal adjustments. Also, it was noted that seventeen out of twenty-nine cases listed as improved found it necessary to return to the hospital once or oftener, leading one to believe that the impact of their previous surroundings caused them to lose the improvement which they had shown in the hospital. Again, familial mental illness seemed to have little bearing on the cases while poor home environment appeared to have a profound impact. There apparently was no correlation between physical trauma and breakdown. Adjustment to marriage is better than might be expected and, of particular interest, was the fact that no woman has had to return because of breakdown during pregnancy or at the birth of a child. There appears to be much room for improvement in the employment status of these patients and the writer feels that intensive work along these lines is indicated. Although the overall adjustment picture, including all of the various phases of social interaction indicates that about half of the adjustments are adequate, the writer is of the opinion that, with the proper culture, this percentage might be substantially greater.

CHAPTER IV

SUMMARY AND CONCLUSIONS

Summary.

From the years 1938 to 1947 inclusive, seventy-one juveniles under the age of eighteen, ranging from nine through seventeen, were admitted to the Milwaukee County Hospital for Mental Diseases. These children comprised only slightly over one per cent of the total number of persons admitted during this period. Therefore, it is reasonable to conclude that this hospital must necessarily be set up for the care of the adult psychotic and is not primarily designed to minister to the needs of children.

As the age of the child advanced, admissions increased substantially, 56% of the admissions being in the sixteen and seventeen year old groups. It was felt that crystallization of behavior in advancing adolescence played only a very small part in the sharply increased commitments. Rather, it would appear from an examination of the facts, that parents failed to recognize psychotic or pre-psychotic behavior and that they rejected the thought that they may have failed as parents. In addition, there seemed to be a natural reluctance to take the emotionally disturbing step of commitment procedures, particularly to an institution which was not specifically designed for the care of children.

Sixty-three per cent of the juvenile admissions were male and 37% were female, which did not necessarily indicate that the male is more prone to mental breakdown than the female. Rather it appeared that the male was inclined toward greater aggressiveness and hence was more openly at odds with society and a greater problem to it. Also entering into the situation was the accepted attitude of greater protection of the female and the fact that less was expected of her as far as her own maintenance was concerned.

At the time this follow-up study was made, 58% of the cases resided outside of institutions; 30% were in mental hospitals; 10%, all male with psychopaths and primary behavior disorders predominating, were in penal institutions and 2 per cent had died. Almost half of these children were schizophrenic, about equally divided as to sex. The fact that 61% of the schizophrenics were currently residing outside was more encouraging than was the actual situation. Many were making no more than marginal adjustments and had been in and out of the hospital many times.

Familial history of mental illness was found in slightly less than half of the cases, leading us to conclude that this factor had little or no bearing one way or the other in the breakdown of these individuals. An examination of the home situations revealed a great lack of family integration and emotional security. Over 70% of the homes were considered very poor with the balance hardly more than adequate, a fact which might well indicate that there is a definite correlation between poorly integrated home life and poorly integrated personality. About 70% were of average intelligence which would lead us to believe that there is little correlation between intelligence and mental illness. Although there is a great tendency in families to base mental

breakdown on physical trauma, the survey revealed that only about thirteen per cent of the cases included physical findings (lues, concussion, high fever, etc.).

From the personality descriptions given by the children's families at the time of admission, seclusive and outgoing natures were almost equally divided. Docile types were slightly in the ascendancy over the tempestuous. However, from an examination of the facts, it was felt that de-emphasis must be placed on the term "outgoing" as interpreted by the family because all of these cases appeared basically egocentric either in a shy, retreating manner or in a hostile, aggressive fashion. Failure to adjust at home and in school formed a blanket complaint.

A follow-up study was made to determine the total adjustment achieved by the forty-one individuals who are currently able to live outside of institutions. This involved a composite of their marriage adjustment, adjustment to the single state (if unmarried), and their employment and social status. Eighteen were considered to be making good adjustments; five, fair; thirteen, poor; and the status of five was unknown. Of the sixty-four cases which we were able to follow up (eliminating two deceased and five in which the present status is unknown) we find only eighteen making what might be considered any sort of satisfactory adjustment whereas forty-six are not. Altogether, this is rather shocking considering the extreme youth of these individuals at the time of their admission, and it leads us to question the efficacy of the treatment which can be afforded children in an institution which is not set up primarily for their care.

Conclusions.

There is no question but that the care given was modern, conscientious and humane but intensity, particularly along psychotherapeutic lines, was lacking because of scarcity of therapists and also of facilities designed especially for the care of children. Follow up care is also at a minimum because of the pressure of hospital load and the fact that the community resources are not set up to handle suitable convalescent conditions and intensive assistance in employment or school planning. To envision what might occur in another situation is purely speculative but the expenditure involved might well defray itself by the reclamation of individuals to productive living rather than consignment of them to an institutionalized or subsidized type of existence whereby they are social and financial burdens throughout their lives.

In the preventive field, increased vigilance and expanded psychiatric services in the schools, closer relations with parents and tactful training of them in mental hygiene, plus greatly increased diagnostic centers and treatment clinics for parents and children could quite conceivably reduce the number of children who might require institutionalization for mental disease. The curative area would involve at least separate hospital quarters for juveniles with specialists in child psychiatry and psychology in attendance plus sufficient staff for intensive operation. Community resources might be explored and community opinion stimulated to a point where eventually suitable foster homes could be found for children who show promise or who, at the present time, return to environments where healthy, emotional growth is impossible. Intensification of out-patient care and follow up after the child has left the hospital to determine his problems and how his needs are being met

would be imperative. The possibilities of greater institution, agency, school and employment co-operation and inter-action should be studied and frequent conferences should be held to analyse progress and to determine what line of planning should be followed to further assist the patient. In other words, releasing one of these children from the hospital without follow-up care seems much like turning loose a ship without a rudder. Their chances of reaching port seem equally remote. All of the time, effort and expense involved may have been to no avail. It is to be hoped that a future, concentrated program will not only reduce the ultimate financial consideration but will achieve something vastly more important—happy, productive living for an increased number of human beings.

APENDIX I

No. of Schedule_____

Case No._____

Personal History

Name
Sex
Age at Admission
Birth Status
Race
Religion
National Extration
Education
Intelligence
Previous Health History

Personality

Sexual History

Family History

Mother
Father
Orphan
Parents separated or divorced
Parents
 Native born
 Foreign born
Economic Level
Known to other agencies
No. of Siblings
 Position in sibling relationship
Incidence of mental illness family

Hospital History

Date of admission
Reason for referral
Diagnosis and Prognosis
No. of admissions
Treatment

APENDIX I (continued)

Hospital History (continued)

Last condition report

Deterioration

Last known status from record

Evaluation of home situation

Last known status on follow-up

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